his attempted suicide were not all equally forgotten. The retrograde amnesia extended only some four or five hours prior to the suicidal attempt. All his preparations for the suicidal attempt were forgotten, and the attempt itself was vehemently denied. It is to be noted that he was oblivious to the events that were going on about him at the time and to the same degree. The physician who attended him for the first few hours had to be re-introduced to him at each visit. The anterograde amnesia was only partial. He remembered having had some suffering, having been in bed and having received the visits of a physician, but he could not recall the latter's name. The anterograde amnesia was not absolute, yet was very pronounced for a period of forty-eight hours. The disturbances of memory lasted for about a fortnight and then gradaully disappeared. It was from the authors that the patient first learned of his attempt at self-destruction. His delusions of persecution, so active just before the hanging, underwent a veritable remission. He was less anxious and disturbed by them than formerly. In fine, his suicidal attempt had abruptly terminated a paroxysm of delirium. After six weeks' confinement his mental state was so much improved that he was set at liberty.

The literature, with its two score of similar reports, relating the cerebral disturbances associated with attempted hangings, is discussed brifly by the authors.

4. *Note Upon Psychasthenic "Distress."*—A definition of this symptom is given and illustrated by three cases. By the feeling of distress, occurring in many psychoneuroses, the author means neither anguish, nor restlessness, nor aboulia, nor indecision, nor fear of solitude, nor need of general supervision. He thinks it is a different and special feeling, a distinct manifestation in the long series of morbid feelings, an independent and individual affective depression or shadow, in a word, "distress" in the ordinary acceptation of the word. As one patient expressed it, "I have no need of anything; I do not fear anything; not even death; and yet my inner eyes dare not encounter the view of the life of to-morrow. I see before me, around me, only an abyss. Where will I find refuge?" The author finds this particular feeling common among his patients who have used and abused the life of pleasure and who have in time reached a high degree of neurasthenia by overindulgence, of weariness by exhaustion, and of disgust by satiety. METTLER (Chicago).

Brain

(Vol. 28, No. 109, Spring, 1905.)

1. The Relation of the Lunacy Laws to the Treatment of Insanity. TUKE.
2. On the Intrinsic Fibers of the Cerebellum, its Nuclei and its Efferent Tracts. CLARKE AND HORSLEY.
3. Diffuse Sarcomatus Infiltration of the Spinal Pia Mater. BARNES.
4. Some Hitherto Undescribed Symptoms in Angina Pectoris. HORSLEY.
5. On a Trigeminal-Aural Reflex in the Rabbit. HORSLEY.
6. A Note on the Condition of the Tendo Achilles Jerk in Diphtheria. ROLLESTON.

Lunacy Laws.—Dr. Tuke in a forceful address brings out in strong relief the disadvantages under which the profession suffers in the treatment of mental diseases, by reason of the inadequacy of the English Lunacy Laws. Physician, patient and public all suffer. He makes a strong appeal for improvement in these laws which cannot fail to be of practical signficance even for us. In England, as in this country, the making of legislation concerning the insanities has lagged wofully behind the progress of the alienists by reason of the gradually shifting point of view, particularly with regard to acute psychoses. The Englishman suffers particularly in so far as the laws are concerned. We cannot go into the details at this place, because of the difference in the laws of England and the United States, but the paper is suggestive for lawmakers here as well as elsewhere.

2. *Intrinsic Fibers of the Cerebellum; Nuclei and Tracts.*—Drs. Clarke and Horsley contribute a lengthy study to the minute anatomy of the cerebellum. They say: "The cerebellum, both in its structure and function, has been the subject of much valuable research during recent years at home and abroad. The anatomy of its lobes and main tracts, their relationship to each other, and the effect upon function of the removal or injury of each of them, have been established on a sound basis. Further progress must depend largely upon a fuller knowledge of its minute structure; and the series of experiments set forth in this paper were undertaken to obtain more precise data on the true anatomical relations of the cortex of the cerebellum with its own and neighboring nuclei, and on the actual origin of the efferent tracts. Two other questions were kept specially in view:—(1) Is there a direct efferent tract from the cerebellum to the spinal cord? (2) And if such a tract really exists, is it derived from the cortex or from the nuclei; and in the latter case, from which nuclei? As far as the cat is concerned the authors believe that the results of their experiments justify the following general conclusions on the direct question whether fibers (presumably axones of the Purkinje corpuscles) pass directly into the cerebellar peduncles or not. (1) No fibers issuing from the cortex cerebelli enter any of the peduncles. (2) All fibers leaving the cerebellum by way of the peduncles have origin in one or the other of the cerebellar nuclei. Their observations show that any given area of the cortex is in relation with a homolateral nucleus of nuclei. They have not found satisfactory evidence that the cortico-nuclear fibers cross the medial plane. The details of these relations are perhaps best shown in parallel columns as follows:

	Portion of Cortex Cerebelli.	*Nucleus with which it is in Relation.*
1.	Anterior pennate lobule.	Nucleus fastigii Nucleus dentatus
2.	Posterior pennate lobule.	Nucleus dentatus
3.	Flocculus, paraflocculus.	Nucleus fastigii
4.	Anterior pennate lobule. Anterior parafloccular lobule Paramedian lobe.	Nucleus dentatus Nucleus globosus Nucleus fastigii Nucleus vestibuli
5.	Omitted for involvement of nucleus fastigii.	
6.	Culmen (five posterior folia).	Nucleus fastigii Nucleus globosus
7.	Culmen and all middle lobe.	Nucleus fastigii Nucleus dentatus Nucleus vestibuli Nucleus globosus
8.	Left half of lobus centralis, culmen and left four fifths of first and second lobule of middle lobe.	Nucleus dentatus Nucleus fastigii Nucleus globosus Nucleus vestibuli
9.	Second lobule of the middle lobe and anterior pennate lobule.	Nucleus dentatus Nucleus fastigii Nucleus globosus Nucleus vestibuli
10.	Three folia of third lobule of middle lobe.	Nucleus fastigii (Very few fibers)
11.	Third and fourth lobules of middle lobe.	Nucleus fastigii

12. Fourth lobule of middle lobe (pyramid).	Nucleus globosus Nucleus dentatus
13. Fourth lobule of middle lobe. and two outer folia of uvula.	Nucleus fastigii Nucleus fastigii
15. Whole uvula.	Nucleus fastigii
16. Ventral half of fourth lobule of middle lobe, uvula, and two anterior folia of uvula.	Nucleus globosus Nucleus fastigii Nucleus globosus Nucleus fastigii
17. Lobus quadrangularis and side of culmen.	Nucleus globosus Nucleus dentatus

The intrinsic arrangement of the cerebellar cortex and nuclei can be regarded as divisible into two distinct organs, a spino-cerebellar and a cerebero-cerebellar system, of which the parts are thus arranged:

Cortex of
Vermis

1. Dorsal Spino-erebellar Tract of Flechsig 2. Ventral Spino-cerebellar Tract of Gowers Spinal Chord Clarke's Column, etc	Nucleus Fastigit Nuclei Vestibuli Spinal Cord Anterior Cornua
1. *Cerebro-cerebellar* Cerebrum Temporal Lobe chiefly Crus Cerebri outer fifth chiefly Pontine Nuclei Middle Peduncle	Cerebrum Red Nucleus and Thalamus Superior Peduncle Nucleus Dentatus

Cortex of
Lateral Lobe

3. *Sarcomatous Infiltration of the Spinal Pia Mater.*—Stanley Barnes contributes a study to the knowledge of the spread of multiple tumors of the central nervous system, and reports the history of the two cases in considerable detail. His conclusions are as follows: (1) If a growth originates in the caudate nucleus or in any other part of the brain and eventually finds its way to the linings of the ventricular cavities, it may "infect" the cerebro-spinal fluid. Metastatic growths may then occur in the following situations: (a) In the lining walls of the lateral, third or fourth ventricle; (b) In the meninges (subarachnoid) at the base of the brain; (c) In the pia mater and the arachnoid around the spinal cord; and (d) In the posterior root ganglia, particularly of the cauda equina. (2) In all probability diffuse sarcomatous infiltration of the spinal pia-arachnoid, which is occasionally found post mortem, is in all cases the expression of a sarcomatous infection of the cerebrospinal fluid as a result of some primary growth which lies exposed to the stream of the cerebrospinal fluid high up in the nervous system. (3) The regions affected by such secondary growths are exactly the same as those affected by tuberculous meningitis after the rupture of a tuberculous "tumor" of the brain.

4. *Angina Pectoris.*—G. A. Gibson gives a clinical lecture on some hitherto unobserved symptoms in angina pectoris, dealing particularly with sensory changes as seen in a patient 45 years of age suffering from this disease. The real importance of this case lies in the opportunity which it affords of giving a clear demonstration of certain facts regarding the afferent impulses from the heart; the symptoms exhibited by the patient allow the possibility of tracing out the course of these paths. Passing

up from the receptive end organ, by the cardiac nerves to the cervical ganglia of the sympathetic, they pass in by the gray rami communicantes to the posterior spinal roots, and thence run upward in the ascending tracts of the spinal cord. In the cortex cerebri the impulses which are produced give rise to sensation, but, as Head puts it, "the sensory and localizing power of the surface of the body is enormously in excess of that of the viscera, and thus by what might be called a psychical error of judgment, the diffusion area is accepted by consciousness and the pain is referred on to the surface of the body instead of on to the organ actually affected." The result is that the patient seems to feel uneasy or painful sensations over the precordia, shoulder and upper extremity. That the cervical sympathetic is involved in this case cannot be denied on account of the ocular phenomena, and the history may be taken as a proof of the contention that this system is a means of conducting afferent impulses from the heart.

5. *Trigeminal-Aural Reflex.*—Dr. Horsley contributes a physiological study of the reflex of the ears in rabbits.

6. *Tendo Achilles Jerk.*—Dr. Rolleston contributes a report of his observation of 100 cases of diphtheria in which the Achilles jerk was investigated up to the time when the patient began to sit up. This period necessarily was widely varied by the severity of the case, the condition of the heart, and the presence or absence of paralysis. In some cases it was as short as twenty days, and in others extended to sixty-three from the onset of the disease. The observations were made with the patient in a recumbent position. In twenty cases the Achilles jerk was completely lost, and in twenty-seven was found to be sluggish. In the other fifty-three cases it remained fully active throughout the whole period. The author summarizes as follows: (1) The tendo-Achilles jerks are affected in a considerable proportion of all cases of diphtheria, though less frequently than the knee jerks. (2) The frequency and extent to which they are affected bear, like albuminuria and paralysis, a direct relation to the character of the initial faucial attack. (3) They are completely abolished in all cases of diphtheritic paraplegia. (4) Their absence may be the only evidence of loss of power in the lower limbs. (5) Like the knee jerks, they are liable to be affected at an early stage of the disease, and to remain absent after diappearance of all diphtheritic paralysis, properly so-called. (6) Like the knee jerks, again, they may be unequally affected on the two sides, and, like the former, they may be unusally brisk before they become sluggish and disappear. (7) The Achilles jerk, like the knee jerk, after it has been lost, may reappear on one side before it does on the other. JELLIFFE.

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6. Studies of a Case of Hemicephalus, with Contribution to the Physiology of the Human Central Nervous System. I. Anatomical Section. II. Clinical Physiological Section. STERNBEG and LATZKO.

7. The Contraction of the Sphincter iridis in Convergence, and the Convergence and Lateral Movements of the Eyeballs. An Experimental Study. MARINA and COFLER.

8. Contribution to the Casuistry and Etiology of Intermittent Claudication. IDELSOHN.

9. A Contribution to the Knowledge of Herpes Zoster. HEDINGER.

10. Brief Communications. I. Remarks upon the article "The Etiology and Pathological Anatomy of Tumors of the Frontal Brain," by Dr. Ed. Muller, Vol. 23, Heft 5 & 6, p. 378. AUERBACH. II. Reply to the Preceding Remarks of S. Auerbach. MULLER.

6. *Hemicephalus.*—By hemicephalus Sternberg means partial absence of the brain, the medulla oblongata and, perhaps other parts, being still recog-